The Commonwealth of Massachusetts
Division of Professional Licensure

Board of Registration of Speech-Language Pathology and Audiology
239 Causeway Street, Boston MA 02114
(617) 727-3071
www.mass.gov/dpl/boards/sp

FORM 2 - SUPERVISED PROFESSIONAL PRACTICE REPORT

THIS PLAN MUST BE COMPLETED, SIGNED, AND RETURNED TO THE BOARD OFFICE WITHIN THIRTY (30) CALENDAR DAYS OF THE COMPLETION OF YOUR SUPERVISED PROFESSIONAL PRACTICE.

INSTRUCTIONS:
- **TYPE OR PRINT IN INK**
- **PLEASE READ CAREFULLY BEFORE COMPLETING**
- **ANSWER ALL QUESTIONS. WRITE "NOT APPLICABLE" IF NO OTHER RESPONSE IS APPROPRIATE**
- **USE ADDITIONAL PAGES IF NECESSARY**
- **IF SUPERVISOR CHANGES PLEASE SUBMIT A FORM II TO COMPLETE THAT PORTION OF THE CFY. NEW SUPERVISOR NEEDS TO SUBMIT A NEW FORM I/FORM II WHEN COMPLETED.**

TO BE COMPLETED BY APPLICANT

1. AREA OF LICENSURE ( )AUDIOLOGY ( )SPEECH-LANGUAGE PATHOLOGY

NAME:_____
(last) (first) (middle)
ADDRESS:_____
(number) (street)
_____
(city) (state) (zip code)

PHONE:_____
(business) (home)

2. PROFESSIONAL PRACTICE RESPONSIBILITIES
List approximate number of hours per week actually spent in each activity.

ACTIVITIES/HOURS PER WEEK

- **A. Diagnostics**_____
- **B. Therapy (totals)**_____
  - **1. language disorders**_____
  - **2. articulation disorders**_____
  - **3. voice disorders**_____
  - **4. fluency disorders**_____
- **C. Aural Rehabilitation**_____
- **D. Identification and Evaluation of Hearing Impairment**_____
- **E. Record Keeping**_____
- **F. Staff Meetings**_____
- **G. In-Service Training**_____
- **H. Other (explain)**_____

3. PROFESSIONAL PRACTICE EMPLOYMENT INFORMATION **SPP REPORT 2**

A. Employer_____
(company name) **(division or department)**
Address_____
(number) **(street)**
_____
(city) **(state)** **(zip code)**

B. Beginning date of employment_____

C. Date Supervised Professional Practice started_____

D. Date Supervised Professional Practice completed_____

E. Number of hours per week in: Audiology_____ **Speech-Language Pathology**_____

TO BE COMPLETE D BY SUPERVISOR

NAME:_____
(last) **(first)** **(middle)**
ADDRESS:_____
(number) **(street)**
_____
(city) **(state)** **(zip code)**
PHONE:_____ _____ _____
(home) **(work)** **(cell)**
Email_____

4. CURRENT LICENSURE STATUS
Audiology_____ **Speech-Language Pathology**_____ **Both**_____

Massachusetts License #_____ **Expiration date**_____
Other state (specify)_____**License #**_____**Expiration date**_____

5. PROFESSIONAL CERTIFICATION:
ASHA/CCC_____**Membership #**_____**Expiration date**_____
AAA/ABA_____**Membership #**_____**Expiration date**_____
None

6. EMPLOYER_____
(employed by) **(division or department)**
_____
(city) **(state)** **(zip code)**

7. SUPERVISION

THE SUPERVISED PROFESSIONAL PRACTICE SUPERVISOR MUST BASE THE TOTAL EVALUATION ON NO LESS THAN 36 OCCASIONS OF MONITORING ACTIVITIES (A MINIMUM OF FOUR HOURS EACH MONTH). THESE MONITORING ACTIVITIES MUST INCLUDE AT LEAST 18 ON-SITE OBSERVATIONS (A MINIMUM OF TWO HOURS EACH MONTH).

METHODS	SESSIONS/MONTH	LENGTH/SESSION	ACTIVITY(see 2)
A. On site observations	_____	_____	_____
B. Remote observations (audio, video tape)	_____	_____	_____
C. Conferences (phone)	_____	_____	_____
D. Review of Records	_____	_____	_____
1. therapy plans	_____	_____	_____
2. diagnostic reports	_____	_____	_____
E. Staff Meetings	_____	_____	_____
F. Case Staffings (placement meetings)	_____	_____	_____

9. RECOMMENDATION OF SUPERVISOR

A. Has the applicant fulfilled professional employment responsibilities?
( ) Yes ( ) No If no, please describe_____
_____
_____
_____
_____

B. I hereby ( ) recommend ( ) do not recommend

_____**for license in the**
(applicant's name)

area of _____
(speech-language pathology or audiology)

_____
(supervisor's signature) **(date)**